Washington State Medicaid Reform
Olympia Town Hall meeting
May 22, 2002

OLYMPIA – About 50 people attended the second Town Hall meeting held to take public comment on the amended Medicaid and SCHIP Reform Waiver proposal to be submitted to the Centers for Medicare and Medicaid Services (CMS). Attendees were a mix of clients and consumer group representatives, health-care providers, legislative staff, and a handful of staff from the Medical Assistance Administration (MAA).

The formal program included an initial presentation by Assistant Secretary Doug Porter on the state's economy and budget crisis, followed by a nuts-and-bolts rundown on the major features of the amended waiver outline by Roger Gantz, Director of the MAA Division of Policy and Analysis. MAA Quality Coordinator Tamishia Garrett moderated the public discussion that followed.

Key points of the Olympia discussion included:

- Parents of disabled children said they were concerned that the waiver would lead to a loss of institutional services that would be devastating to their children and their families. Gantz explained that the amended waiver would not affect long-term care or institutional services currently being provided by Washington state.

- What would be the role of the Legislature in the waiver? Porter and Gantz noted that the agency would not proceed with approved waiver decisions unless it had signoff from the Legislature. In fact, some parts of the proposed waiver – adding premiums and co-payments, for example – would probably require implementing legislation or concurrence by legislators.

- What is different about the amended waiver? One person at the meeting said she had attended last fall's meetings on the initial waiver proposal and found it pretty much identical to the discussion this time around. Gantz and Porter noted that the initial waiver had asked the federal government for a broad range of options to deal with skyrocketing expenditures. Those proposals were criticized by CMS, legislators, and stakeholders as too vague and unrestricted. As a result, Gantz and Porter said, the amended waiver will instead list the specific options and the circumstances in which the state would use them.

- Several people asked: Won't hospital emergency room co-payments be a problem to collect, and won't they be ineffective since hospitals cannot refuse care? Porter acknowledged that all the pieces of this puzzle were not assembled, and that MAA was assuming the responsibility of making sure that provider access is available in the first place. "We've been looking at a number of ways to get better physician participation," Porter said. "Thurston County is a good example, where even state employees have difficulty locating primary care doctors. We're looking at ways to expand the provider network. But I still think you've got to do both, find some way to relieve the crunch on the ER, too…We heard from providers in Spokane last night that a lot of the people using the ER are being driven by convenience…so I think we've got to do both."

- The proposed drug co-payments also drew some comment. Porter noted that CMS has been fairly receptive to the concept of adding a co-pay to prescription drugs in those cases where the client is insisting on a brand-name drug and refusing to accept generic or therapeutic

equivalents. (There would be no co-pay if the prescriber feels the higher-priced drug is medically necessary.) Porter stressed that the both co-payments – on brand-name drugs and non-emergency use of emergency rooms – were being proposed to change behavior, not to raise revenue. He said the program would be happy if no one ever has to pay either co-pay.

Other comments:

▶ "I was wondering where you came up with the maximum of 5 percent that each family would have to pay in co-pays or premiums? You take some $20 a month, that's a lot of money for somebody who is on SSI."

▶ "My son is profoundly disabled and institutionalized…You told us about how the projections for Medicaid are going through the ceiling, and I can't see that all the efforts that are being made to save money are going to save anywhere near that amount of money…so effectively that means that we're going to slam the doors of those institutions shut, and I oppose that. I think there's another way we have to go about that. There are not many other ways to deal with violent behavior…I know of a case in Walla Wall, where someone had to live behind plexiglass windows with the dinner shoved under the door. That person is now in a state institution and being cared for. But that same kind of person is not going to be able to get in if the front door is shut… That's my primary issue."

▶ "I'm familiar with ER usage, and I know that some people who go there are really in need of care. They try to go to their doctor and they can't get in and can't get care….so they go to the emergency room, and the get there and they have to pay $10 to get care. I heard you say that's inappropriate care, but that's not inappropriate! I urge you to take a good look at these two issues. Don't penalize people who are being forced into using emergency rooms just to get care."

▶ "I have huge concerns about the co-payment issue. A few years ago, there was a program for primary care doctors to be contacted by emergency rooms to see if it was OK to treat this patient. Then we learned that this whole program was illegal. Under the law, if a reasonable person decides it's an emergency, it's an emergency. So now there's a question of liability if someone doesn't get treated, and the liability probably rests with the hospital. I think that's a huge responsibility to place on these people when their reimbursement is being cut. We can't deny them access, and if we do and the kid goes home and dies at 2 a.m. in the morning, who's to blame? The whole thing won't work, let alone the 10-buck co-payment that nobody will have…."

▶ "Have you looked at ways to build capacity in the community so that clients can have reasonable access to practitioners so they don't have to go to the emergency rooms?"

▶ "Hassling doctors about name-brand drugs and demanding paperwork that takes time, these are things that work against access. In effect, you're making the emergency rooms more attractive to clients."

▶ "I know that there were earlier meetings with advocate groups who have expressed significant opposition to the waiver, and some of those groups even met with CMS and also expressed opposition there to the whole idea of a waiver. So if you did hear significant opposition to a waiver in these Town Hall meetings, would you drop the idea and go back to the drawing board? Or is the waiver a foregone conclusion?"

▶ "I guess I'm a little concerned by the answer given to the gentleman who's being told that his son won't be affected by the waiver, because the waiver hasn't been written and under that logic, nobody in the room is going to be affected."

▶ "You're saying you're going to get the new waiver written, and you're saying you can write the entire Medicaid waiver in the space of 10 days or two weeks from whole cloth…and that would be a remarkable feat! Can it really be done that quickly or would it be an administrative miracle?"

▶ "There were a number of people who asked last year that they were clients and asked if they would be affected and they were told no you won't be, but it turned out they would have been."

▶ "I work at Morton General Hospital, and we're having an increasing number of DSHS people coming through and we're now having a special person try to obtain services…The co-payment at the emergency room will place a burden on them to determine if this person does have a co-pay and I assume that the person would come in without the money, and we've got a $10 co-pay and it costs us about $10 to file a claim to get payment, and nobody gets payment on the first claim – essentially it's becoming another write-off for the hospital when we're already having trouble with too many write-offs."

▶ "And how do you know that the sore throat really turns out to be a sore throat and not something else?"

▶ "I was at every single one of the hearings during the last round of waiver meetings…I was at every single one of those, and what you said about them, that's NOT what happened…. Significant opposition was raised (to all these issues), and the same issues were raised -- the co-payments, the premiums -- and significant opposition to all of those was raised. So what is the difference now? Even though those were not written in the waiver, those were the types of things that people talked about. It's just that the same issues are still the same issues. Those issues have not gone away."

▶ "You need to consider the impact of the cuts that you may have to make. There was an article today in The Olympian about a study that showed how people who are not covered by insurance get sicker more often and are more likely to die. Then in Oregon, there was news that people there have decided to limit their costs with people who have HIV. It shows the tremendous impact of rationing, and how you can go down that slope…."

▶ "I have to say I'm very disappointed. It seems like from what everybody is saying that premiums and co-pays are barriers to care, a headaches and a problem – so why are you continuing to propose them? What are you doing about drug costs, which is the major driver for the state's expenditures? Why don't we leverage the real power? And if we could do that one thing, we could turn that around. Fix the drug problem!"

▶ "You mentioned that the waiver is going to save tens of millions of dollar and yet we're facing a billion dollar problem. So it seems to me that we're punishing the poorest of the poor, and not solving the problem either. The Federal Poverty Level (FPL) for a family of four is $17,000. I'm a single man with an income of $35,000 and I don't feel like I make all that much money….It doesn't add up. It doesn't make sense."

▶ "Overall, health care costs on society are going to be much, much higher (under the waiver) than spending the money needed to fix the problem. Although that might be tougher on the state budget, I think we can figure that part out because the costs to society would be so high."

▶ "I'd like to give some positive feedback about the Therapeutic Consultation Service. As a physician, we have to get approvals from many different insurance companies for different prescriptions, and I spend less time on the phone with the TCS than I do with the plans. The TCS information is accurate and it's quick. If it were available on line, it would be even more convenient for me."

▶ "I also want to echo concerns about premiums. I think Roger (Gantz) made some mention of the state and how some time ago it started cost-sharing for those folks in their second six months of TANF…if they pay a premium at a certain percentage of their premium. The information made available to us about the amount of money that the state expected to get in revenue, the cost savings that the state expected to achieve was several million dollars, so my feeling was that the object was to save the state money, and frankly some people in MAA told me privately that it was scandalous for the state to be doing that. I have the same reaction to the idea of extending premiums to optional groups."

▶ "We are going to lose chunks of people even if fairly small premiums are imposed on clients. We're going to lose kids, and we're going to lose adults as well."

▶ "If the SCHIP population is frozen…we could have kids' enrollment frozen and kids being put on waiting list while we actually extend coverage to adults at the same time by using unspent SCHIP dollars to fund the Basic Health program. This doesn't make sense. There just has to be some other way to do this."

▶ "I'm curious about what's being done to attract more money to the Medicaid program….I see this in part as the refusal of people to pay for the needs of the poor. Why are the poor being neglected? This isn't right at all. Somebody needs to do something more aggressive than coming up with ideas for 1115 waivers."

▶ "It's an entirely different world today. A few years ago, we had a big rainstorm and a bridge up in Seattle sank, and the very next morning, we had state and national leaders coming to us and saying we need to raise that bridge and we'll come up with the money."

▶ "The whole thing is backward. We're so concerned about a $5 or $10 co-pay from these folks! Why aren't we working to come up with an adequate payment for doctors so they would be willing to accept them as patients? By the time doctors see them, we're talking hospital admission because they have waited so long to get care…There are very few physicians in Thurston County who will see these people. If you can't get doctors to participate, then the $5 or $10 co-pay or a premium isn't going to matter."

▶ "Are you trying to save Medicaid dollars by attrition? Working it so that families aren't going to be able to afford the premiums under the waiver?"